

Financial Information

Self Pay

I do not currently have insurance coverage for mental health services (or do not wish to utilize my benefits) and will assume full responsibility for payment of services received at the time they are rendered.

Credit Card Authorization

Accept my signature below as authorization to bill my _____ Visa _____ Mastercard

Account # _____ Expiration Date _____ CVV _____

For Therapeutic services in the amount of \$ _____ as they occur for the following client(s)

I give permission to Dr. Saponaro to bill my credit card for missed appointments when not cancelled 24 hours in advance.

The authorization will remain in effect until such time as it is revoked in writing. I certify that I am an authorized signer of the account number provided.

Name as it appears on card

Signature

Date

Insurance Information

Primary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)

Member ID#: _____ Group#: _____

Customer Service # _____

Primary Insured Name: _____ DOB: _____

Relationship to client: _____

Secondary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)

Member ID#: _____ Group#: _____

Customer Service # _____

Insured Name: _____ DOB: _____

Relationship to patient: _____

I hereby attest that I am, at the time of this appointment, an eligible member of the insurance carrier(s) listed above and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all deductible, co-insurance, and services not covered by insurance

